

Request for Confidential or Alternative Methods of Communication

You have the right to receive confidential communications from Atrium Health in a different way or at a different location. For example, you can ask that we only contact you at work or by mail. We will honor reasonable requests. We will also ask how payment will be handled and how you would like to be contacted to address payment issues.

To request an alternative method of communication, complete this form, and submit it to the Atrium Health Facility or Practice where you were treated. To find the address of the appropriate Facility or Practice, please go to www.AtriumHealth.org and select "Location".

Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____

I request Atrium Health communicate with me in the following way:
(Check one and complete necessary information)

By mail at: _____

(Please note this is the address Atrium Health will use for all mailings to you. Atrium Health is unable to administer more than one mailing address for a patient.)

By telephone at: _____

Other: _____

Tell us how we may contact you for payment: _____

I understand that requesting this alternative method of communication may interfere with Atrium Health's ability to contact me in a medical emergency.

I understand and agree that, if I cannot be located by the alternative method requested, Atrium Health may use any available contact information to locate me in the event that (1) Atrium Health determines there is a medical emergency or similar situation in which my health is at risk if I am not contacted immediately; or (2) if I have not provided adequate information on how payments will be made.

Signature of Patient or Representative: _____ Date: _____

If signing as authorized representative, describe your authority to act for the patient, and submit documentation showing such authority, as appropriate: _____

For Atrium Health Use Only

Alternative communication method has been: ___ Accepted ___ Denied

Signature(s): _____ Print Name: _____ Date: _____

Comments: _____

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Place Patient Label Here